PRINTED: 02/03/2011
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155064	A. BUILDING _____ B. WING _____	C 01/31/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRMONT REHABILITATION CENTER, LLC	3518 SOUTH LAFOUNTAIN STREET KOKOMO, IN 46902

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for the investigation of complaint IN00085182. Complaint IN00085182 - Substantiated, federal/state deficiencies related to the allegation are cited at F-223. Survey date: January 31, 2011 Facility number: 000025 Provider number: 155064 AIM number: 100274850 Survey team: DeAnn Mankell, RN. Census bed type: SNF: 10 SNF/NF: 53 Total: 63 Census payor type: Medicare: 17 Medicaid: 42 Other: 4 Total: 63 Sample: 6 Fairmont Rehabilitation Center LLC was found to be in substantial compliance with 42 CFR part 483 subpart B and 410 IAC 16.2 in regard to the investigation of complaint number IN00085182. Quality review completed 2-2-11 Cathy Emswiller RN	F 000	F-223 *The corrective action taken for the resident affected by deficient practice is that the* resident identified as resident A is no longer a resident in the facility. *The corrective action taken for those residents found to be affected by this deficient practice is that* the resident A was interviewed as well other residents within the same care area by social services concerning the allegation of abuse and is documented in the clinical record to reflect that the resident suffered no negative outcome from the event. Statements from facility staff members who were on duty were included in our investigation process. The C.N.A involved in the incident was immediately suspended and was terminated after our completed investigation.	1-31-11 JW

approved 3/10/11 DF

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE Exec. Dir | (X6) DATE 2/7/2011

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

AH
"A" FORM

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 155064	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 1/31/2011
NAME OF PROVIDER OR SUPPLIER: FAIRMONT REHABILITATION CENTER, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE: 3518 SOUTH LAFOUNTAIN STREET KOKOMO, IN		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 223	483.13(b), 483.13(b)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION

The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.

The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.

This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to ensure staff to resident abuse did not occur for 1 of 2 investigations of alleged abuse reported in the past 6 months for 1 of 2 residents with allegations of abuse in a sample of 6 (Resident A).

Findings include:

1. An allegation of abuse, which was reported by the facility as occurring on 1/11/11, involving Resident A was reviewed on 1/31/11 at 11:15 A.M.

Review of the "Incident/Accident Report" dated 1/12/11 midnight, indicated ".... Daughter called facility to report. Resident requested CNA assist c (with) HS (bedtime) care et help resident return to her bed from BR (bathroom). CNA very rude et abrupt c [with] resident. CNA using foul language in presence of resident. Stated to res. when she asked for assistance from bathroom to bed. You got in there on your own you can get out.... CNA suspended immediately. All staff inserviced on Abuse...."

Resident A's daughter had called the facility on 1/12/11 around midnight informing the facility of a phone call she had received from her mother, Resident A.

The written statement from LPN #1 dated 1/12 was reviewed on 1/31/11 at 11:15 A.M. and indicated, "Around midnight I received a phone call from (name) (Resident A)'s daughter. She said (Resident A) called her & told her that a member of staff was rough c (with) her when taking her from bathroom back to bed. She said the person grabbed her arm & told her that if you can take yourself to the bathroom then you can take yourself back to bed. Daughter also said that res c/o (complained of) call light not being answered fast enough. I told daughter that since I'd been here her call light hadn't been on but that I would definitely find out what was going on. I asked my CNA (name of CNA #2) if she had taken (Resident A) to the bathroom tonight. She said yes that she had taken her from bathroom back to her bed & that she held onto her arm while assisting her. After she told me that I checked on res & res was in her bed asleep so I called you & reported it. You told me to send CNA home, so that's what I did."

Review of the faxed report to ISDH [Indiana State Department of Health] indicated CNA #2 was terminated from the facility after the investigation of abuse was completed.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

AH
"A" FORM

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 155064	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 1/31/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRMONT REHABILITATION CENTER, LLC	3518 SOUTH LAFOUNTAIN STREET KOKOMO, IN

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 223	Continued From Page 1 During an interview with the administrator on 1/31/11 at 5:15 P.M., he indicated the CNA was terminated for abuse. This federal tag relates to complaint IN00085182. 3.1-27(b)